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RHEUMATIC MALARIAL FEVER

N. BARLOW

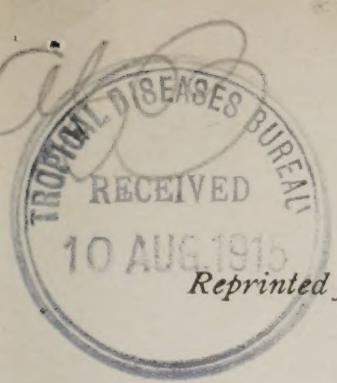
American Journal of Tropical  
Diseases and Preventive Medicine  
1914, 1.



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*Reprinted from the American Journal of Tropical Diseases and Preventive Medicine, Vol. I, No. 12, June, 1914, pp. 865-867.*

## RHEUMATIC MALARIAL FEVER.

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The writer has recently had a series of eight cases which suggest the existence of a rheumatic form of malarial fever. The first case was at a distance from the hospital, and the first blood specimen taken was lost, resulting in a three weeks treatment with alkalis and salicylates. The patient grew steadily worse. When a second slide showed crescents, the treatment was discontinued and quinine administered. He returned to work in ten days.

The second patient came with a typical herpes zoster in the region of the first lumbar nerve. Two days later the picture was that of acute articular rheumatism. After one day of salicylate medication he developed a violent active delirium, and in spite of quinine in large doses, he died three days later.

The third, after two days of salicylate, developed aphasia and inability to swallow. Quinine was given intravenously, with recovery. In the five cases following, an immediate searching examination of the blood revealed the parasite, and they made prompt recoveries upon quinine, only one case being prolonged more than two weeks.

The condition may first appear as a neuralgia, as herpes zoster, or as a severe lumbar or sacral pain; or it may from the start be a multiple arthritis. The joints are involved in rapid succession, and there is the same tendency to jump from one to another that is seen in articular rheumatism. The affected joints are not hot or red, and are much less swollen than in rheumatism. The exquisite pain of severe cases of rheumatism is never seen. The swelling is partly within and partly without the joint, is entirely serous in character, and leaves no perceptible changes on subsiding. A simultaneous carditis or pericarditis may occur, completing the picture of rheumatism. Each occurred once in this series, but upon recovery the heart and pericardium were clinically normal in each case.

Fever may be very slight or absent. It is rarely as high as in rheumatism and there is usually not more than one rise in any one day. The profuse sweating of rheumatism does not occur. As to whether there are subvarieties of the estivo-autumnal parasite, the writer is not able to say, but it is certain that this condition indicates a severe form of the fever, and is very likely



to be followed by some one of the so-called malignant complications.

*Treatment.*—Complete rest in bed and attention to the bowels, together with a light diet, are of course indispensable. Quinine must be pushed to the limit of toleration, combined with moderate doses of bromide. The synovial surfaces seem to be difficult to reach with small doses of quinine, and it is better to give the daily amount in one dose. By far the best method is the intravenous injection of 15 to 25 grains each of quinine bichloride and sodium bromide in a liter of freshly distilled water. In view of the frequency of serious complications in these cases, it would be best to treat every case in this manner for one or two days. Salicylates and alkalies in large doses aggravate the pain, prolong the course, and make the condition more resistant to quinine. A single dose of 5 to 8 grains of aspirin may be given daily to relieve pain; much more will increase the pain.

If serious complications do not occur before two days of quinine therapy, the prognosis is entirely favorable for complete restoration to normal.

It is interesting to note that many text-books advise the use of quinine in cases of rheumatism which resist the salicylates; that the books state that "some cases" of herpes zoster are promptly relieved by large doses of quinine combined with various other remedies; and that many practitioners of large experience in malarial regions contend that the best treatment for rheumatism is with calomel and quinine.

There is no doubt but that genuine articular rheumatism occurs in the Tropics with greater frequency than the form described above. We have had 12 cases of indubitable rheumatic fever during this same period, which followed the usual course and yielded in the usual way. And of course rheumatic fever might occur in a patient already infected with malaria. It would seem safer to regard any patient with the clinical differences described above, and who has malarial parasites in his blood, with the proportion of polynuclear cells decreased instead of increased, as suffering from rheumatic malaria, and to withhold salicylates and administer quinine. In this hospital a more rigid rule will be followed, on account of unpleasant experiences in the past. Any patient with apparent rheumatism will be subjected to immediate, thorough search for malaria. If found, he will be put to bed, given an immediate intravenous injection of quinine and bromide, and considered as a case of malaria for several days.

The number of cases of malaria treated by this department during the period was 334. This would correspond to 950 cases in the population from which the cases were drawn, showing that less than 1% of cases of malaria take the rheumatic form.

